



Colon Cancer: An Atypical Clinical Presentation

Urbina-Cabello, José de Jesús

General Surgeon, Surgical Department at “Dr. Rubén Leñero”
General Hospital Secretary of Health of Mexico City, National
Autonomous University of Mexico, México City, México

García-Sánchez, Morelos Adolfo

Colonic and Rectal Surgeon and General Surgeon, Surgical
Department at “Dr. Rubén Leñero” General Hospital Secretary
of Health of Mexico City, National Autonomous University of
Mexico, México City. México

Méndez-Barrón, Gema

General Surgeon, Surgical Department at “Dr. Rubén Leñero”
General Hospital Secretary of Health of Mexico City, National
Autonomous University of Mexico, México City, México

De La Fuente-González, Mireya

General Surgeon, Surgical Department at “Dr. Gaudencio
González Garza” General Hospital Specialized Medical Unit,
“La Raza”, National Medical Center, Mexican Social Security
Institute, National Autonomous University of Mexico, México
City, México

Flores-Pazos, Mauricio Israel

General Surgeon, Surgical Department at “Dr. Rubén Leñero”
General Hospital Secretary of Health of Mexico City, National
Autonomous University of Mexico, México City, México

Hernández-Salvador, Judá Raquel

General Surgeon, Surgical Department at “Dr. Rubén Leñero”
General Hospital Secretary of Health of Mexico City, National
Autonomous University of Mexico, México City, México

González-Valiente, Mariana

General Surgeon, Surgical Department at “Dr. Rubén Leñero”
General Hospital Secretary of Health of Mexico City, National
Autonomous University of Mexico, México City, México

Romero-Guzmán, Elsa Nalleli

General Surgeon, Surgical Department at “Dr. Rubén Leñero”
General Hospital Secretary of Health of Mexico City, National
Autonomous University of Mexico, México City, México

Ortiz-Ramirez, Mario Rogelio

General Surgeon, Surgical Department at “Dr. Rubén Leñero”
General Hospital Secretary of Health of Mexico City, National
Autonomous University of Mexico, México City, México

Martínez-Gandarillas, Carlos Alberto

General Surgeon, Surgical Department at “Hospital
Universitario de Puebla” Universidad Benemérita Autónoma
de Puebla. Private Hospital. City of Puebla Mexico

Cruz-Pacheco, Salomón

General Surgeon, Surgical Department at “Dr. Rubén Leñero”
General Hospital Secretary of Health of Mexico City, National
Autonomous University of Mexico, México City, México

ABSTRACT

Introduction: Colon and rectal cancer are the third neoplasm in incidence and the second in mortality worldwide. In the United States of America, it is the second most common neoplasm and the incidence in Mexico is unknown, the prevalence and morbidity, as well as its mortality. **Aim:** Case report and literature review. **Method:** 74-year-old female in the emergency department. It presents with leukocytosis and systemic inflammatory response due to wall abscess, emergency surgery is performed, with the discovery of cecum tumor, multivisceral resection is performed. Satisfactory evolution and diagnosis of colon cancer. **Discussion:** The clinical presentation of colon and rectal cancer is so varied, it will depend on the anatomical site of the colon (right/left) or rectum, primary tumor, synchronism, age, anatomical differentiation or histological lineage. Right colon cancer due to its physiological characteristics tends to be more complex in terms of its timely diagnosis, with the intervals of signs and symptoms to a longer-term diagnosis. The technical objectives of a surgery with the intention of being curative must have the circumferential resection margin, the distance of healthy tissue from the tumor and the lymph node dissection, avoiding hemorrhage in the surgical dissection so as not to implant micro metastases. **Conclusions:** The form of clinical presentation of colon cancer can be very varied, masked or simulated by another disease, its rarity or very low incidence, evokes the group of researchers to make this experience known.

Keywords: Cancer, Colon cancer, Rectal cancer, Multivisceral, Circumferential resection, Neoplasia.

INTRODUCTION

Colon and rectal cancer (RCC) are the third neoplasm in incidence and the second in mortality worldwide, in the United States of America it is the second most common neoplasm and the incidence in Mexico is completely unknown, the prevalence and morbidity, well, like his

mortality. [1, 2, 3, 4] "Mexico does not have a single coordinating entity for cancer prevention, there is not federal program for screening colonoscopy, there is no national policy or national cancer registry, and there is no data complete and accurate information on the scope and social impact of the RCC." [1]

In the history. Hippocrates of Cos (460–379 BC) is the first to describe the existence of colon cancer, it was not until John Hunter (1728–1793), shared by Morgagni, who were the first to propose surgical excision for the treatment of rectal cancer., and it was in 1739 when the first rectal resection was performed by Jean Faget. [5]

It is alarming that RCC is increasing exponentially in its incidence worldwide and this result is also seen in the young population. [6] In this study of 217,202 cases, there is an increase in the incidence of RCC in patients under 50 years of age, it has predominated in males 4:1 in relation to females. With a mean age of 69 years, survival was 8.7%. [7] In recent publications, it has been documented that the excess mortality from colorectal cancer is impressive. [7, 8]

OBJECTIVE

Case report and literature review.

CASE REPORT

74-year-old female admitted to the emergency department, with no chronic-degenerative history, surgical history with appendectomy and wall plasty; it began three weeks prior to admission, with stabbing abdominal pain of moderate intensity that had gradually increased, with a palpable tumor in the abdomen at the level of the previous surgical wound of the abdominal plasty, irregularly and without prior medical treatment. It presents with intermittent fever of 38.7° C., nausea, and intermittent vomiting of gastric and food contents. On physical examination with vital signs, P/B: 95/55 mm Hg., HR: 94 x'. BF: 20 x'. SatO2: 94%. Size: 1.54 m. Weight: 55 Kg. Conscious, with +++ pale integuments, dehydrated mucous membranes. Globular abdomen at the expense of adipose panniculus with tumor at the level of the mesogastrium and right flank of irregular shape, with a previous scar and of imprecise measurements, with erythema, edema, serous exudate. No signs of peritonism, peritoneal irritation and/or acute abdomen. Laboratories: with leukocytosis of 18,800 /mm³, neutrophilia of 81.20%, microcytic microchromic anemia hemoglobin 9.80 g/dl, hematocrit 31.10%, thrombocytosis of 709,000 U/L, hyponatremia of 132 mEq/L, potassium 3.83 mEq/L, calcium 8.5 mg/dl, total bilirubin 0.4 mg/dl, urea 47.7 mg/dl, creatinine 0.65 mg/dl, hypoalbuminemia 2.4, hyperglycemia 160 mg/dl, C-reactive protein 16.7 U/L, glutamic oxalacetic transaminase 12 U/L, alkaline phosphatase 167 U/L, gamma-glutamyl transferase 47 U/L. Arterial blood gas: pH 7.47, PCO₂ 23 mm Hg, PO₂ 82 mm Hg, lactate 2.6 mmol/L, SO₂ 97%. Abdominal ultrasound with the presence of soft tissue abscesses in the right iliac fossa measuring 52 x 32 mm, and another deeper one measuring 81 x 50 mm, as well as an abdominal collection of 500 ml in the pelvic cavity. The computed tomography study showed an abdominal collection with a large, heterogeneous ascending colon mass effect, with septa inside. He underwent emergency surgery performing extended radical right hemicolectomy with terminal ileostomy and distal closure; figure 1 and 2, for an abscessed tumor of the cecum and ascending colon measuring 15 x 14 x 11 cm, with 400 ml of purulent content.



Figure 1

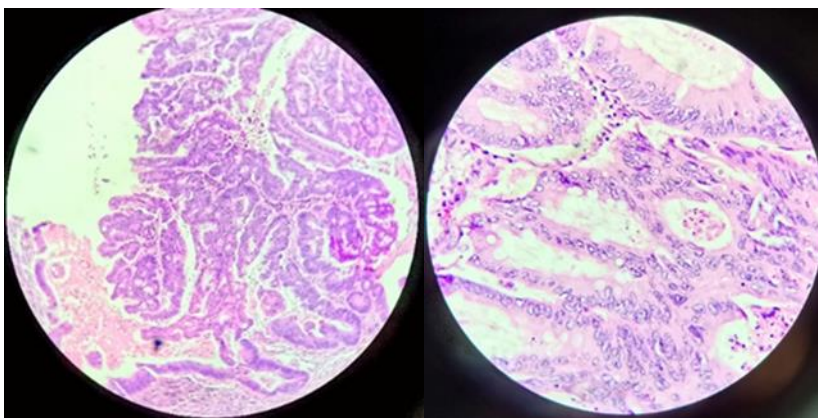
Macroscopic appearance of stenosing adenocarcinoma of the right colon. On the left, segmental resection of the ileum is observed.



Figure 2

Cut surface of colon adenocarcinoma that narrows the intestinal lumen.

His post-surgical evolution was adequate and he was discharged home with follow-up in the specialty clinic. The histological report “moderately differentiated and invasive adenocarcinoma in the cecum measuring 12 x 8 x 7 cm, figure 3 and 4, without macroscopic perforation, acute reactive peritonitis, and 21 lymph nodes without metastasis.” The patient is referred to a specialized oncology center for extension studies and specialized treatment.

**Figure 3****Figure 4**

Histological sections with panoramic view of well-differentiated infiltrating colon adenocarcinoma with atypical glands. Hematoxylin and eosin.

DISCUSSION

RCC can infiltrate continuously or exceptionally, the tumor cells spread intraluminally and metastasis occurs with an implantation mechanism far from the primary tumor, which makes an accurate diagnosis and equally effective and forceful therapy difficult; [9] the mechanism of implantation is probably the development of a synchronous tumor, and with an anecdotal incidence.

The urgency or surgical emergency in a patient with RCC, not diagnosed or protocolized, is 30% in developed countries in their health system, [10, 11] on the contrary in countries that are not developed, such as Mexico, it has been reported. 60 to 70% as published. [12, 13] And for the same reason, emergency resection for colorectal cancer has a greatly reduced overall and tumor-specific survival, compared to patients undergoing elective resection, up to 50% less. [10]

The clinical presentation of RCC is so varied or diverse that it will depend on the anatomical site of the colon (right or left) or rectum, the primary tumor, the synchronous tumor, the patient's age, anatomical differentiation or histological lineage, among others; [14] in addition, unexplained weight loss (severe chronic malnutrition and/or cachexia), anemic syndrome, wasting syndrome, asthenia, adynamia, hyporexia, nausea, gastric fullness, occasional vomiting, chronic constipation, abdominal distention, chronic to intermittent diarrhea symptoms with the presence of lower gastrointestinal bleeding, occult blood in feces present and many other signs and symptoms. [15] Right colon cancer due to its physiological characteristics tends to be more complex in terms of its timely diagnosis, with the intervals of signs and symptoms to a longer-term diagnosis. [16] These characteristics that they offer allow exponential growth of the tumor, and it is because the cecum and the ascending colon are of large diameter, they are distensible, adaptable, they handle almost 95% of the intestinal content is liquid, they present a high absorption rate, 98% of the water in the intestinal contents is reabsorbed in the right colon, as is bleeding, among other factors. [17, 18] This chronicity or time of onset of the clinical picture masks RCC or simulates other pathologies, such as a wall abscess of a supposed benign etiology, with an extremely rare incidence. [19] The diagnosis is made based on suspicion,

according to the clinical scenario or, failing that, in the same surgery, as a finding, consequence or etiology of what was considered another disease. [11, 20]

The study protocol includes a thorough and complete clinical history, with a well-performed physical examination, with regard to a different protocol aimed at each patient specifically, such as a complete colonoscopy, even intraoperative (rule out synchronism), thoracoabdominal computed tomography, nuclear magnetic resonance, PET/SCAN and histological report; for correct staging, and then, an adequate or correct medical and/or surgical treatment, with the scenarios of neoadjuvant, adjuvant, palliative, curative and even preventive. [21, 22, 23] It is reiterated that in addition to the stage in which the patient is at the time of diagnosis, the anatomical data must be taken into account, which have been documented frequently in 65% of patients with RCC had a tumor on the left side of the colon, 27.7% on the right side and 7% in the transverse colon, and lastly, 16.8% of all patients had rectal involvement. [24] Another factor that impacts the development or growth of a truly large tumor is the histological lineage, where the degree of differentiation allows slow to very slow growth (which can be as many as 3, 5, or up to 7 years). [25] The study that is the gold standard is colonoscopy, since it plays a role in RCC, providing a diagnosis (biopsy), treatment and can even be preventive. [18, 26]

The treatment of RCC is surgical and all other resources are focused on strengthening this first, with the aim of giving the patient a possible cure option. The standard of care for patients with stages II and III rectal cancer remains preoperative (chemo)radiation followed by surgical resection. [27] Likewise, after possibly curative surgical management, older patients receive chemotherapy and radiotherapy more frequently, with an increased mortality reported at 7.6% vs 1.35 in the colon and 10.3% vs 0.7% in the rectum, compared in patients under 50 years of age. [28] The fundamental strategic technical objectives of an oncological surgery, with the aim of being curative, must have the circumferential resection margin, the distance of healthy tissue from the tumor and the lymph node dissection, avoid hemorrhage in the surgical dissection so as not to implant micro metastases, 2 cm disease-free circumference ranges. And longitudinal 5 cm in the colon and 2 cm in the rectum at each end, with a lymph node dissection of 18 lymph nodes in the pericolic, intermediate and main colon and in the upper mesorectum of 12 lymph nodes, to be considered complete and effective. [29] The surgical approaches that have been documented with very similar results are conventional, laparoscopic and robotic; there are no differences in the overall survival of the patient, but there are exponential costs respectively, or colectomy through surgery to extract samples through natural orifices. [29, 30, 31, 32, 33].

Multivisceral surgery such as pelvic exenteration for the treatment of rectal and/or anal cancer should generally be offered only in cases of resectable disease and with curative intent, although reported mortality ranges from 20 to 80%. [34] Multivisceral resection can be performed safely with acceptable postoperative mortality and gives the possibility of obtaining radical ablation in locally advanced RCC, which is one of the key prognostic factors for overall survival. In addition to surgical free margin, other identified prognostic predictors for overall survival were node positivity, receipt of adjuvant chemotherapy, and age. [35] Today, colonoscopy is the perfect instrument in the galenic arsenal for adequate detection, prevention and even cure of RCC, since it has no precedents in terms of efficiency and/or effectiveness in these areas. [36, 37, 38]

CONCLUSIONS

RCC is a neoplasm that has increased its incidence and mortality worldwide, and it is alarming that in Mexico there is no health policy that projects the real situation in the country. The form of clinical presentation of RCC can be very varied, masked or simulated by another disease, its rarity or very low incidence, prompts the group of researchers to make this experience known. Emergency surgical intervention for other reasons and with the discovery of RCC, requires the surgeon to have the respective oncological competence in terms of expertise, decision, technique and resources and supplies, in order to offer the best option to the patient. The curative treatment is surgical in RCC with all its strengths and weaknesses, with the synergy of chemotherapy, radiotherapy, immunotherapy; therefore, so it depends on individualize each patient in an exquisite and jealous manner, to grant greater survival.

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